

# HEART DISEASE ACTION PLAN



Name: \_\_\_\_\_

Medical Provider's  
Name: \_\_\_\_\_

Case Manager's  
Name: \_\_\_\_\_

Medical Social Worker's  
Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

## THINGS TO DO EVERYDAY:

- ☐ Take my medicines as directed
- ☐ Take aspirin or another blood thinner to protect my heart if recommended by my medical provider
- ☐ Keep a healthy weight
- ☐ Eat a healthy diet which includes lots of fruits and vegetables
- ☐ Eat low fat dairy products
- ☐ Eat a diet high in fiber and low in fat
- ☐ Limit alcohol and caffeine
- ☐ Read labels for hidden salt
- ☐ Reduce stress
- ☐ Exercise regularly or as recommended by my medical provider

## MY PLAN:

I will call my medical provider today if:

- ☐ I have more frequent or severe episodes of chest pressure or pain
- ☐ The chest pressure causes sweating or shortness of breath
- ☐ The chest pressure goes into my arm or neck
- ☐ The chest pressure changes in location or intensity

I will call 911 if:

- ☐ I have chest, throat or arm tightness, pain or pressure with or without shortness of breath, a cold sweat or nausea that does not go away with rest or after taking my medicine
- ☐ The pain or symptoms are the same as they were before my last heart attack



## THINGS TO AVOID:

- ☐ Adding salt to my diet
- ☐ Eating food high in salt
- ☐ Smoking or using tobacco products
- ☐ Stress
- ☐ Foods with saturated fats, especially trans fats found in snack foods

## GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:
Date:	My LDL Cholesterol:	My Goal:
Last Lipid Profile done:		Next Lipid Profile due:

## DISCUSS WITH MY MEDICAL PROVIDER:

- ☐ What to do if I have chest pain or heart symptoms
- ☐ Changes in diet
- ☐ Activity/Exercise
- ☐ Medicine for my heart, such as Beta Blocker/ACEI/ARB, statins or nitrates
- ☐ Pneumonia vaccine
- ☐ Flu vaccine

## NOTES

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## MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)

Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important      1   2   3   4   5   6   7   8   9   10      Totally important  
☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident      1   2   3   4   5   6   7   8   9   10      Totally confident  
☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐   ☐

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):